

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13336



5 - SUMMARIES

000001

FINAL DIAGNOSES:

1. Lacunar stroke related to small vessel disease.
2. Chronic hypertension.
3. Hypercholesterolemia.

PROCEDURES: MRI scan of the brain, MRA, CT scan of the brain, transesophageal echocardiogram.

REASON FOR ADMISSION: Stroke.

HISTORY: This is a 47-year-old white female admitted with a left-sided weakness. A couple days prior to the admission, the patient developed some leg weakness and slight difficulty with walking. A day prior to admission, she was slightly wobbly on her feet but was able to go to work. The same day, she was seen at [REDACTED] and discharged. Overnight, she got out of bed and fell down at 3:00 a.m. There was left upper and lower extremity weakness and she was numb but ambulatory since.

She attributed the initial symptoms to "flu" because her husband developed some body aches. She denied any chest pain or headache or any irregularities or arrhythmia in the heart. On admission, her blood pressure was 195 systolic and she has never checked it before. She has been taking an herbal diet medication containing ephedrine. She had a drink with caffeine and alcohol and jumped into the hot tub the night prior to the admission.

PAST MEDICAL HISTORY: Surgeries: Tonsillectomy at age 30, cesarean section in the past. She had a fracture of the toe last summer and right arm fracture as a child. Illnesses: She is unaware of any hypertension problem herself but it runs in the family. She was not sure if she was diabetic although diabetes runs in the family as well. She had a renal infection, remote, in the past. Otherwise, she denied any medical problems.

CFSAN Project #13336
02/17-19/1999
MMA MMA

MEDICATIONS: None.

ALLERGIES: She is not allergic to any medications.

ATTACHMENT # 4.3

FAMILY HISTORY: Father deceased at age 53 because of COPD. Mother is alive at age 70. She has one brother and three sisters. One sister died at age 47 with hypertension and some abdominal problems but died of massive myocardial infarction. She has one son who is healthy. There is a family history of diabetes in a sister and mother. Sister, father and a few uncles have heart disease. High cholesterol runs in a sister and mother.

SOCIAL HISTORY: She denied any cigarette smoking. She drinks two to three drinks per day of alcohol. She uses ephedrine daily as a part of herbal medicine. She denied any caffeine use although does use soda pop. She has been married for 29 years and has one child. She works for an electronics company and lives with her family.

PT NAME: [REDACTED] DATE: 02/03/99

PHYSICIAN: [REDACTED]

MR#: [REDACTED]
ACCT#: [REDACTED]

DISCHARGE SUMMARY REPORT

000002

DISCHARGE SUMMARY REPORT

REVIEW OF SYSTEMS: She did not gain or lose any weight in the past six months. She denied any unusual stressful situation. She has a chronic problem with inability to fall asleep immediately, for which she takes Advil. She may have some concurrent hip problems that prevent her from sleep, as well. She has some trouble with waking up at night, as well. She denied any cough, fever, recent immunizations, blackouts, chest pain or pressure, irregular heart beat, abnormal swelling in the feet or pain in the calves. She may have some cramps and restless legs for some time. She denied any headaches, seizures, slurred speech, double or blurred vision, dizziness, change in urination or stomach trouble. She had some gas last week. Otherwise, the review of systems is negative.

PHYSICAL EXAMINATION: VITAL SIGNS: B/P 195/92 on admission, T 98.8, P 86, R 20. GENERAL: The patient appeared to be comfortable and attentive throughout the history-taking and examination. VASCULAR: No carotid bruit. LUNGS: Clear to auscultation and percussion. HEART: Rate was regular. She had a soft ejection murmur at the base of the heart. No peripheral edema or tenderness was noted. NEUROLOGIC: The patient was alert and oriented. The language, memory, fund of knowledge, attention and concentration were normal. Cranial nerves: Fundusoscopic examination revealed sharp disks bilaterally. The visual fields were full to double stimulation. The pupils were equal and reactive to light. The extraocular movements were intact. The facial sensation was slightly decreased on the left. The face was symmetric. The hearing was normal. The uvula and palate elevated symmetrically. The shoulder shrug was symmetrical. The tongue protruded in midline. Motor evaluation: The neck was supple with free range of movements. The muscle tone was normal in the right side and slightly decreased on the left. She had weakness on the left side, graded at 3-4/5. The deep tendon reflexes were slightly increased and graded as 2+/4. The response to plantar stimulation was equivocal on the left but possibly suggestive for the upgoing toe. It was not consistent. Sensory examination was decreased by 50% on the left side. The coordination testing was normal on the right side with finger-to-nose, finger-finger-to-nose and rapid alternating movements. It was difficult to assess the left side coordination because of weakness. She would circumduct the left lower extremity with walking and require assistance of one to two persons for support.

LABORATORY RESULTS: The CT scan of the brain was performed on 01/30/99, and showed the 1 cm irregular hypodensity in the posterior aspect of the right basal ganglia, involving the posterior lip of right internal capsule, consistent with subacute lacunar infarct. A 5 mm hypodensity in the left external capsule was also noted. MRI scan of the brain, the formal report of which is not available at time of dictation, confirmed these findings. She had bilateral deep basal ganglia infarcts seen on MRI scan. There was no abnormal large vessel stenosis on MRA. She underwent transesophageal echocardiogram on 01/31/99, which showed normal left ventricular systolic function and mild aortic insufficiency. No thrombus or patent foramen ovale. The laboratory tests for antithrombin-3, cardiolipin antibody, lupus anticoagulant, protein C and S, were all negative. Her cholesterol was 212, triglycerides 169, HDL 43, LDL 135 and a VLDL of 34. Therefore, she has elevated cholesterol with low HDL, elevated LDL and VLDL. She had normal CBC, urinalysis, comprehensive metabolic panel, bilirubin,

CFSAN Project #13336
02/17-19/1999
MMA MMA

ATTACHMENT # 4.4

PT NAME: [REDACTED]
PHYSICIAN: [REDACTED]

DATE: 02/03/99

MR#: [REDACTED]
ACCT#: [REDACTED]

hemoglobin A1C, uric acid and serum electrophoresis. The sed rate was 9. Her blood pressure was monitored throughout the hospital stay and was initially elevated at the time of admission and then was in the 150-166 range, systolic.

HOSPITAL COURSE: The patient was admitted with left-sided weakness and evolving stroke. She was markedly hypertensive at the time of admission with 196/98 blood pressure. She had been taking herbal diet medication containing ephedrine. She also used some drinks containing caffeine and alcohol and used the hot tub prior to the admission. In-hospital investigation failed to reveal any cardioembolic source. She underwent a transesophageal echocardiogram, which revealed no abnormalities except for mild aortic insufficiency. Hypercoagulable screen was performed which revealed normal antithrombin-3, cardiolipin antibody, sed rate, lupus anticoagulant, protein C and protein S. Her cholesterol was slightly elevated to 212, with low HDL to 43, high LDL to 135 and VLDL high to 34. It was decided that the patient should have a dietician to see for any diet modification. She may need future repeat lipid panel and depending on results, use lipid-lowering agent if necessary.

MRI scan revealed a lacunar stroke in the right internal capsule as well as external capsule lacunar infarct on the left, supporting the diagnosis of small vessel disease. She had been hypertensive since admission, although the blood pressure slowly lowered throughout the hospital stay. She was placed on atenolol 50 mg a day prior to discharge. Throughout the hospital stay, she was kept on aspirin 325 mg once a day and at the time of discharge, was switched to 325 mg b.i.d. for stroke prevention. She continued physical therapy throughout hospital stay with some improvement in the function.

DISPOSITION: She was discharged in stable condition to [REDACTED] for further rehabilitation. She is to continue physical therapy as well as speech and OT at [REDACTED]. She is to see a dietician for diet modification and increased activity level. She is to follow up with me after she is discharged from the [REDACTED]. The patient may require lipid-lowering agent if diet modification is not successful. Further decisions regarding her management will be made at the time of the clinic visit. The key element in future management will be the optimal management of hypertension, to prevent any future strokes associated with longstanding hypertension. She is being transferred in stable condition to [REDACTED].

DISCHARGE MEDICATIONS: Atenolol 50 mg q.d. and aspirin 325 mg b.i.d.

[REDACTED] M.D.

CFSAN Project #13336
02/17-19/1999
MMA MMA

PAT: [REDACTED] DIC: [REDACTED] M.D.
EVD: 01/30/99 D: 02/03/99 T: 02/03/99
C: [REDACTED]
TYPIST: [REDACTED] JOB # [REDACTED] BATCH: [REDACTED]

ATTACHMENT # 4.5

PT NAME: [REDACTED] DATE: 02/03/99
PHYSICIAN: [REDACTED]

MR#: [REDACTED]
ACCT#: [REDACTED]

DISCHARGE SUMMARY REPORT

000004

REASON FOR ADMISSION: Stroke.

HISTORY OF PRESENT ILLNESS: This is a 47-year-old white female who is being admitted because of left sided weakness. Late Thursday, that is two days ago, she developed some leg weakness and had slight difficulty with walking. The day prior to admission, she was slightly wobbly on her feet but was able to work. The same day, she checked in at [REDACTED] from where she was discharged. Last night at 3 a.m. she got up out of bed and fell down. She had some upper and lower extremity weakness. Since then, she has been slowly improving. She attributed the initial symptoms to flu because her husband developed some body aches.

The family brought her into the emergency room because she was unable to walk. She denied any chest pain or headache. She denied any irregularities in the heart beat. She had no recent illnesses. On admission, her blood pressure was 195 systolic. She has not checked her blood pressure at all. There was a significant premature atherosclerotic disease in the family as well as diabetes.

PAST MEDICAL HISTORY: SURGERIES: Include tonsillectomy at age 30, and Cesarean section. She had fracture of the toe last summer and right arm fracture as a child. ILLNESSES: She is unaware of any hypertension problem but it runs in the family. She does not know if she is diabetic, but it runs in the family. She had a renal infection, remote in the past. She denied any medical problems otherwise.

CFSAN Project #13336

02/17-19/1999

MMA mmm

MEDICATIONS: She is on no medications.

ALLERGIES: She is not allergic to any medications.

ATTACHMENT # 4.6

FAMILY HISTORY: Father deceased at age 53 because of COPD. Mother is alive at age 70. She has one brother and three sisters. One sister died at age 47 who had hypertension and some abdominal problems but died of massive myocardial infarction. She has one son who is fine. There is a family history of diabetes in sister and mother. Heart disease in sister, father, and some uncles. High cholesterol runs in sister and mother.

SOCIAL HISTORY: She denied any cigarette smoking. She drinks two to three drinks per day of alcohol. She denied any caffeine use. She has been married for 29 years, has one child. She works for an electronics company. She lives with her family.

REVIEW OF SYSTEMS: She did not gain or lose any weight in the past six months. She denied any unusual stressful situations. She has a chronic problem with falling asleep for which she takes Advil because of concurrent hip problems. She has some trouble with waking up at night. She denied any cough, fever, recent immunizations, blackouts, chest pain or pressure, irregular heart beat, abnormal swelling in the feet, pain of calves. She may have some cramps and restless legs for some time. She denied any headaches, seizures, slurred speech, double or blurred vision, dizziness, change in urination, or stomach

PT NAME: [REDACTED]

DATE: 01/30/99

MR#: [REDACTED]

PHYSICIAN: [REDACTED]

ACCT#: [REDACTED]

trouble. She had some gas last week. Otherwise, the review of systems is negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: B/P 195/92, T 98.8, P 86, R 20.
GENERAL: The patient appears to be comfortable and attentive throughout the history taking examination.
GENERAL VASCULAR: Examination reveals no carotid bruit.
LUNGS: Clear to auscultation.
HEART: Rate is regular. She had the soft ejection murmur at the base of the heart. No peripheral edema or tenderness is noted.

NEUROLOGICAL/MENTAL STATUS:

The patient is alert and oriented. The language, memory, fund of knowledge, attention, and concentration are normal. Cranial nerves, fundoscopic examination reveals sharp disks bilaterally. The visual fields are full to double stimulation. The pupils are equal and reactive to light. The extraocular movements are intact. The facial sensation is slightly decreased on the left. The ^{face} patient is symmetric. The hearing is normal. The uvula and palate elevates symmetrically. The shoulders ~~round and shrug is~~ symmetrical. The tongue protrudes in midline. ~~Rotary motor~~ evaluation, the neck is supple with free range of movements. The muscle tone is normal on the right side and slightly decreased on the left. She has a weakness on the left side, grade this IV/V and on an ^{NH} stroke scale it was one point on the left upper extremity and one point on the left lower extremity. The deep tendon reflexes were slightly increased and the last grade is II+/IV. The response to plantar stimulation was equivocal on the left. Sensory examination was decreased on the last by approximately 50% in the left upper and lower extremity. The coordination testing revealed a normal finger-to-nose, finger-finger-nose, and rapid alternating movements on the right and due to weakness on the left, it was difficult to assess. The gait, the patient circumducted the left lower extremity and required assistance of 1-2 persons for support.

CFSAN Project #13336
02/17-19/1999
MMA mwa
ATTACHMENT # 47

LABORATORY DATA: Reviewed and no major abnormalities were noted.

Some of the history was obtained from the family members. I have discussed the case with maybe about the patient being admitted.

IMPRESSION:

1. Ischemic stroke, with sensory and motor deficit, most likely embolic versus small vessel disease etiology.
2. Hypertension.
3. Strong family history of premature atherosclerosis due to diabetes and hypertension.

PT NAME: [REDACTED]
PHYSICIAN: [REDACTED]

DATE: 01/30/99

MR#: [REDACTED]
ACCT#: [REDACTED]

PLAN:

1. The patient will be admitted to the special care for further management.
2. Hypertension will be closely monitored and if it is persistent, it will be aggressively managed. The first couple of days will be closely monitored and if elevated above 210 systolic or 120 diastolic it will be aggressively treated. Otherwise the patient will be running higher blood pressures to avoid any deterioration of the deficit if it is acutely treated.
3. She will be started on aspirin 325 mg once a day.
4. Speech pathologist will assess her swallowing prior to any oral feeding.
5. She will undergo a ^{transesophageal} ~~transverse~~ Echocardiogram for any intracardiac pathology.
6. She will undergo a 24 Holter monitor for any cardiac arrhythmia such as atrial fibrillation that could be contributing to her symptoms.
7. She will undergo a carotid duplex ultrasound for any ~~external~~ ^{extracranial} ~~cranial~~ carotid disease related to her stroke.
8. MRI imaging as well as MR angiogram for extra or intracranial stenosis will also be performed.
9. The patient will be started with physical therapy and occupational therapy for ambulation.
10. She will undergo further investigation for any presence of deficiencies in phospholipid antibodies, sed rate, ANA, serum electrophoresis and urine drug screen.
11. Full lipid profile will be drawn and she will be evaluated for any presence of underlying diabetes mellitus.

[REDACTED]

M.D.

PAT: [REDACTED] DIC: [REDACTED] M.D.
EVD: 01/30/99 D: 01/30/99 T: 01/30/99
C: [REDACTED]
TYPIST: [REDACTED] JOB # [REDACTED] BATCH: [REDACTED]

CFSAN Project #13336
02/17-19/1999
MMA mma

ATTACHMENT # 4.8

PT NAME: [REDACTED] DATE: 01/30/99 MR#: [REDACTED]
PHYSICIAN: [REDACTED] ACCT#: [REDACTED]

MEDICAL RECORD

DATE OF REQUEST 1/30/99 TIME 1155 REQUESTING P [REDACTED] CONSI [REDACTED]

REQUEST CONSULTATION:

OPINION ONLY CONCURRENT CARE REFERRAL FOR ASSUMPTION OF CARE

REASON FOR CONSULTATION: Stroke

FINDINGS AND RECOMMENDATIONS:

DATE OF CONSULTATION 1/30/99

47 y/o pt c onset of @ newspaper's stated
Thursday evening. Last night fell, in progress.
BP 195/92 T 98° P 86 R 20
Neurologically @ sensor-motor deficit c 9 DTRs
and equivocal Babinski. Circumduct.
No carotid bruit. Soft ejection murmur (systolic)
Impressos: Ischemic stroke, embolic vs small-vessel.
Hypertensive, essential vs reactive to stroke
Stroke family history of DM & HTN

- Rx : - admit to special care to my care
- start ASA 325 mg qd
- TEE
- Carotid duplex U/S
- MRI/MRA (extra & intracranial)
- start PT/OT
- special for swallow assessment

[REDACTED]

CFSAN Project #13336
02/17-19/1999
MMA MMA

ATTACHMENT #4.24

REASON FOR ADMISSION: Comprehensive stroke rehabilitation program.

DISCHARGE DIAGNOSES:

1. Left hemiparesis secondary to right basal ganglia lacunar infarct on 01/30/99.
2. Hypertension.

COMPLICATIONS: None.

CFSAN Project #13336
 02/17-19/1999
 MMA MMA

CONSULTATIONS: None.

ATTACHMENT # 5.8

PROCEDURES: None.

DISPOSITION: Discharged to home with her husband. She was ambulating several hundred feet independently with a cane at the time of discharge, and had gross grasp on the left arm.

DISCHARGE MEDICATIONS: Aspirin one p.o. b.i.d.; atenolol 50 mg p.o. q.d.

PLAN: She is to follow up with Dr. [REDACTED] her neurologist, within three or four weeks regarding the etiology of the stroke. Follow up with Dr. [REDACTED] regarding rehabilitation issues, in four weeks. Outpatient OT and PT will be done at the [REDACTED]

HISTORY: This is a 47-year-old mother of one, a small business manager, who developed left hemiparesis with sputtering onset on 01/30/99, for which she was admitted to [REDACTED]. Her deficit became much worse on 01/31/99. Transesophageal echocardiogram and carotid Dopplers were unremarkable. MRI/MRA showed two lacunar infarcts, right greater than left, in the deep basal ganglia. Initial blood pressure was 195/98. She was begun on aspirin therapy by Dr. [REDACTED] her neurologist at [REDACTED]

On 02/03/99, she was transferred to the Rehabilitation Center at [REDACTED]. At the time of admission, she was alert and oriented but had left and central facial droop and left arm weakness, approximately 2/5 proximally, no movement distally but sensation intact. Leg strength was 2/5 proximally, 1/5 in the quadriceps, with no movement distally and sensation intact. There was an extensor plantar response. She could stand with fair balance and weightbear on the left.

REHABILITATION COURSE: She made good steady progress throughout the rehab stay. There were no significant complications other than symptoms of cold and flu, which were treated symptomatically and with a short course of amantadine. This resolved by the time of discharge.

She advanced steadily toward ambulation independently with a cane. By the time of discharge, she could ambulate several hundred feet. There was some improvement in the left arm strength. By the time of discharge, she could lift her arm to head level and had a gross grasp on the left. She also had improvement in left leg strength but required a posterior leaf spring AFO to assist with gait.

Routine Discharge Summary Report

Page 2

MED REC#: [REDACTED]
Unit #: [REDACTED]
Visit #: [REDACTED]

Lipid studies were repeated and showed a cholesterol of 168, which was within normal limits, triglyceride of 207, which was in the high-normal range, a low HDL of 35, high VLDL of 41, but normal LDL of 92. No further measures were taken regarding the lipids at this time. She followed with Dr. [REDACTED] regarding this.

Blood pressure remained stable on the atenolol. At the time of discharge, it was 120/63.

Followup plans are noted above.

[REDACTED] M.D.

cc: [REDACTED] M.D. [REDACTED]

PAT: [REDACTED] DIC: [REDACTED] M.D.

EVD: 02/03/99 D: 02/13/99 T: 02/13/99

C: [REDACTED]

TYPIST: [REDACTED] JOB # [REDACTED] BATCH: [REDACTED]

CFSAN Project #13336
02/17-19/1999
MMA MMA

ATTACHMENT # 5.9

[REDACTED] [REDACTED] 02/13/99

000010

REASON FOR ADMISSION: Comprehensive stroke rehabilitation program.

HISTORY OF PRESENT ILLNESS: This is a 47-year-old mother of one from [REDACTED] who developed left-sided weakness early in the morning on 1/30/99. She went to [REDACTED] where her strength was approximately 4/5 on the left. She could ambulate with assistance. Her blood pressure was 195/98. CT scan showed a small right basal ganglia lacunar infarct. She was seen by Dr. [REDACTED] of neurology as her attending.

The next day her left-sided weakness was greatly increased. A transesophageal echocardiogram and carotid Doppler were unremarkable. MRI and MRA of the brain on 1/31 reportedly showed two lacunar infarcts, larger on the right than the left, in the deep basal ganglia. The one on the right was believed to be the cause of the hemiparesis. There has been some modest improvement in her strength since that time. She has been able to ambulate with assistance but not move her hand. She handles a regular diet well. She was put on 1 aspirin per day. The cause of the stroke was believed to be hypertension. She had been taking some herbal diet pills containing about 40 mg of ephedrine as well as some caffeine on the day of the stroke.

PAST MEDICAL HISTORY: Significant for a C-section and tonsillectomy, but no other significant hospitalizations or surgeries. She did have a broken right arm as a child.

ALLERGIES: No known medical allergies.

CURRENT MEDICATIONS: Medications at the time of transfer included 1 aspirin p.o. b.i.d.; atenolol 50 mg p.o. q.d.

FAMILY HISTORY: Significant for diabetes, COPD, and vascular disease.

SOCIAL HISTORY: She has been married for 29 years and has a 21-year-old child who is now out of the home. She works as a manager of a small electronics firm. Her husband works out of the home. She doesn't smoke but drinks moderately, she states. She denies any previous problems with alcohol.

REVIEW OF SYSTEMS: She denies any problems with vision, hearing, swallowing, pain, diarrhea, constipation, breathing, or voiding. She has some left facial numbness which is getting better, she states.

PHYSICAL EXAMINATION:

VITAL SIGNS: Ht approximately 4 feet 11 inches.
 GENERAL: A middle-aged appearing white female, in no acute distress. She is alert and cooperative.
 HEENT: Normocephalic, with sclerae and oropharynx clear.
 NECK: Supple.
 CHEST: Breath sounds clear throughout.
 HEART: Heart sounds unremarkable; rhythm regular.

CFSAN Project #13336
 02/17-19/1999
 MMA MMA

02/03/99

ATTACHMENT #5.1

000011

Medical History/Physical Report

Page 2

MED REC#: [REDACTED]
Unit #: [REDACTED]
Visit #: [REDACTED]

ABDOMEN: Soft and nontender; bowel sounds present.

EXTREMITIES: No cyanosis, edema, or asymmetric swelling; no contracture.

NEUROLOGIC: Alert, oriented and cooperative. No evident language or cognitive problems. Visual fields and extraocular movements are full. She has mild to moderate left facial droop. The tongue is midline. She has good strength and coordination of the right arm and leg. Left arm strength is 2/5 proximally with no distal movement, and triceps is trace only. Sensation is intact to elbow simultaneous stimulation on the left. Left leg strength is 2/5 proximally with 1/5 quadriceps and no dorsiflexion, trace plantar flexion. She has extensor plantar response. Sensation is intact. Joint position sense is scratch in the left leg. She stood with minimal assistance and fair imbalance with weightbearing on the left, but could not take a step without moderate assistance.

IMPRESSION:

1. Left hemiparesis secondary to right basal ganglia lacunar infarct on 1/30/99.
2. Hypertension.
3. Elevated serum cholesterol.

PLAN:

She is admitted to the rehabilitation center for comprehensive stroke rehabilitation program. We will continue the aspirin and atenolol, watch her blood pressure and address her hypercholesterolemia with diet initially. Mini dose heparin will be started for the DVT prophylaxis. She will be mobilized and ADLs and functional skills assessed by OT and PT. Speech therapy will reassess swallowing and cognitive skills. It is unlikely she will need prolonged therapy there. Psychology will see her regarding adjustment issues. Our overall goal will be to restore independence in ambulation with an AFO and gait aid, and to restore independence in one-handed ADLs. Hopefully there will be significant return in the left arm, but this is too early to predict the degree of function she will have there.

DISPOSITION GOAL: Home with her husband.

ESTIMATED LENGTH OF STAY: One to two weeks to accomplish this. She will need prolonged outpatient therapy, regarding the left arm particularly.

[REDACTED] M.D.

CFSAN Project #13336
02/17-19/1999
MMA MMA

cc: [REDACTED] M.D.

PAT: [REDACTED] DIC: [REDACTED] M.D.
EVD: 02/03/99 D: 02/03/99 T: 02/04/99

ATTACHMENT # 5.2

02/03/99

000012

[REDACTED]
Page 3

Medical History/Physical Report

MED REC#: [REDACTED]
Unit #: [REDACTED]
Visit #: [REDACTED]

C: [REDACTED]
TYPIST: [REDACTED] JOB # [REDACTED] BATCH: [REDACTED]

CFSAN Project #13336
02/17-19/1999
MMA m m A

ATTACHMENT # 5.3

[REDACTED] [REDACTED]
02/03/99

000013

REHABILITATION CENTER REPORT

Page 1

MED REC#: [REDACTED]
Unit #: [REDACTED]
Visit #: [REDACTED]

REHABILITATION PSYCHOLOGY DISCHARGE SUMMARY: From 2/03/99 to 2/13/99

PRIMARY PHYSICIAN: [REDACTED] M.D.

RELEVANT HISTORY: The patient suffered left hemiparesis secondary to a cerebrovascular accident. For further information about her medical history, please see the history and physical by Dr. [REDACTED] which is in her current medical record.

PREMORBID PSYCHOLOGICAL STATUS: This married, 47-year-old, Caucasian female is right-handed. She completed high school and resides in [REDACTED]. She has worked 21 years in business as an office manager handling shipping and a variety of other things. She denies a history of depression, anxiety or other emotional problems. She denies a history of learning disability. She indicated that she did have a traumatic brain injury previously when she fell in the third grade when she was climbing. She got hooked on the coat rack and fell and was unconscious for a short time. The patient did not receive medical attention for this. She denies a history of use of tobacco. She does consume alcohol one to two times a week. She also indicated that she has used marijuana including within the last two to three months.

MENTAL STATUS EXAMINATION: Mental status changed in the course of hospitalization. She showed a lessening of her depression and a good response to treatment.

PROBLEMS ADDRESSED IN COURSE OF HOSPITALIZATION:

1. Treatment for adjustment disorder with depression. Supportive treatment was provided. Concepts and skills were given to assist her in understanding how to manage her life and to maintain her sense of self-identity and manage some of the stresses and problems which felt actually had triggered the stroke. This was successfully completed during the course of hospitalization.
2. Preparation for discharge. We discussed challenges that she would face and ways for coping as well as information about the expected period of adjustment after discharge. She indicated that she understood these and was prepared to apply the skills which were taught to her. This goal was also felt to be successfully met in the course of hospitalization.

DISPOSITION: The patient was discharged home to the care of her family.

[REDACTED] PH.D.

CFSAN Project #13336
02/17-19/1999
MMA MMA

PAT: [REDACTED] DIC: [REDACTED] Ph.D.
EVD: 02/13/99 D: 02/16/99 T: 02/17/99
C: [REDACTED]

ATTACHMENT # 5.6

REHAB, PSYCHOLOGY

02/13/99

000014

Page 2

REHABILITATION CENTER REPORT

MED REC#: [REDACTED]
Unit #: [REDACTED]
Visit #: [REDACTED]

TYPIST: [REDACTED] JOB # [REDACTED] BATCH: [REDACTED]

CFSAN Project #13336
02/17-19/1999
MMA *mmh*

ATTACHMENT # 5.7

[REDACTED]

REHAB, PSYCHOLOGY

02/13/99

000015

REHABILITATION CENTER REPORT

Page 1

MED REC#:

Unit #:

Visit #:

REHABILITATION PSYCHOLOGY INITIAL INTERVIEW: 2/03/99

PRIMARY PHYSICIAN: [REDACTED] M.D.

RELEVANT HISTORY: The patient suffered left hemiparesis secondary to a cerebrovascular accident. For further information about her medical history, please see the history and physical by Dr. [REDACTED] which is in her current medical record.

PREMORBID PSYCHOLOGICAL STATUS: This married, 47-year-old, Caucasian female is right-handed. She completed high school and resides in [REDACTED]. She has worked 21 years in business as an office manager handling shipping and a variety of other things. She denies a history of depression, anxiety or other emotional problems. She denies a history of learning disability. She indicated that she did have a traumatic brain injury previously when she fell in the third grade when she was climbing. She got hooked on the coat rack and fell and was unconscious for a short time. The patient did not receive medical attention for this. She denies a history of use of tobacco. She does consume alcohol one to two times a week. She also indicated that she has used marijuana including within the last two to three months.

MENTAL STATUS EXAMINATION: She was dressed in clean, fresh, modest clothing. Hygiene was good. Facial expression was worried. Motor activity was normal except for decreased movement on the left. Interview behavior was normal. Flow of thought was clear, coherent and logical. She showed no expressive or receptive impairment. Speech was normal. Content of thought focused on concern to recover and to get back to her family and work. Insight and judgement were both good. Mood was depressed. Affect was responsive. There were no delusions, hallucinations, illusions or ideas of reference. She was fully oriented to time, place and person. She showed no deficits in recent or remote memory. Intellect was estimated to be above normal.

DIAGNOSTIC IMPRESSION:

1. 309.0, adjustment reaction with depression.
2. 438.20, cerebrovascular accident.

PATIENT GOALS: The patient's goal is to return home and pick up her life as quickly as possible. She requested assistance with her emotional adjustment and preparing her for discharge. The patient's goal will be to participate in therapy. These goals were discussed with the patient who concurred with them and requested that these services be provided to her. She appears to have good ability to benefit from neuropsychological services.

CFSAN Project #13336

02/17-19/1999

MMA MMA

[REDACTED] PH.D.

ATTACHMENT # 5, 4

REHAB, PSYCHOLOGY

02/03/99

000016

Page 2

REHABILITATION CENTER REPORT

MED REC#: [REDACTED]
Unit #: [REDACTED]
Visit #: [REDACTED]

PAT: [REDACTED] DIC: [REDACTED] Ph.D.
EVD: 02/03/99 D: 02/16/99 T: 02/17/99
C: [REDACTED]
TYPIST: [REDACTED] JOB # [REDACTED] BATCH: [REDACTED]

CFSAN Project #13336
02/17-19/1999
MMA MMA

ATTACHMENT # 5.5